UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

IN RE WORLD TRADE CENTER LOWER MANHATTAN DISASTER SITE LITIGATION	**ORDER TO SHOW CAUSE REGARDING DECEASED PLAINTIFF**
JAN SALWA, Plaintiff, -against- DAVID MEDINA, 3D MUSIC GROUP LLC, and ALEX TAPIA, Defendants.	08 Civ. 2707 (AKH) 21 MC 102

ALVIN K. HELLERSTEIN, U.S.D.J.:

Plaintiff Jan Salwa filed a Complaint on February 22, 2008, alleging that he suffered multiple physical ailments, including hypertension, cardiac problems, and lung and prostate cancer, as a result of debris removal work performed in the months following the September 11, 2001, terrorist attacks. Plaintiff's wife, Irena Salway, claimed derivatively for her losses due to the injuries sustained by her husband. On December 4, 2012, Plaintiff's case was selected to proceed towards trial and complete pre-trial discovery along with other so-called Phase II cases in the 21 MC 102 master calendar.

It has come to the Court's attention that Plaintiff Jan Salwa died on June 4, 2009, four years ago. Rule 25(a)(1) of the Federal Rules of Civil Procedure provides that if a party dies, a motion for substitution of the proper party may be made by any party or by the decedent's successor or representative. "If the motion is not made within 90 days after service of a statement noting the death, the action by…the decedent must be dismissed." Fed. R. Civ. P. 25(a)(1).

Plaintiff did not move for substitution, even to this day. As seen in the attached documents, Irena Salwa signed verifications to discovery submissions "as personal representative of the estate of Jan Salwa" in September and November 2011. Plaintiff's counsel also appears to have submitted authorizations for the release of medical records with Jan Salwa's signature dated December 17, 2009, six months after his death.

It is hereby ordered that Plaintiff shall show cause by June 24, 2013, why this action should not be dismissed for failure to substitute Jan Salwa as a party within 90 days of notice of his death. Plaintiff's counsel shall explain why he submitted supplemental discovery responses not verified by the injured Plaintiff himself as Rule 33(b)(1)(A) requires.

SO ORDERED.

Dated: June 12, 2013
New York, New York

ALVIN K. HELLERSTEIN
United States District Judge

08CV02707

VERIFICATION

Potwierdzam, ze powyzsze odpowiedzi sa prawdziwe i prawidlowe zgodnie z moja wiedza. Mam swiadomosc, ze jezeli ktorekolwiek z powyzszych odpowiedzi sa falszywe, to ja podlegam karze.

Pewne fakty i sprawy okreslone w tych odpowiedziach nie sa wziete z mojej wiedzy, a informacje te i fakty zostaly zebrane przez moich adwokatow Worby Groner Edelman & Napoli Bern, LLP na podstawie dokumentacji medycznej, dokumentow i innych informacji zebranych przeze mnie i moich adwokatow.

Dated: 9/15/11

Signature Irena Salwa

Irena Salwa, as Personal Representative of the Estate of Jan Salwa

17389

08CV02707

CERTIFICATION

Pursuant to 28 U.S.C. §1746, I certify under penalty of perjury that I have reviewed those questions and answers contained in the database docket 21MC102/103 (AKH) with reference to my individual claim, and those responses are true and correct.

Executed M. 14, 2011

Signature Irena Salwa

Irena Salwa, as Personal Representative of the Estate of Jan Salwa

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Jan Salwa	[redacted]	[redacted]
Patient Address 100 Greenpoint Avenue, Apt. #2R, Brooklyn, NY, 11222		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name and address of health provider or entity to release this information:
Robert Fusco MD 80 Wyzmist Bldg 205 NY NY [illegible]

8. Name and address of person(s) or category of person to whom this information will be sent:
WORBY, GRONER, EDELMAN & NAPOLI BERN, LLP, 3600 Sunrise Highway, Suite T-207, Great River, NY 11739

9(a). Specific information to be released:

☒ Medical Record from (insert date) 1995 to (insert date) Present

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: ____________________

Include: (Indicate by Initialing)

______ Alcohol/Drug Treatment
______ Mental Health Information
______ HIV-Related Information

Authorization to Discuss Health Information

(b) ☒ By initialing here JS I authorize Robert Fusco, MD
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:
WORBY, GRONER, EDELMAN & NAPOLI BERN, LLP
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: Litigation	The conclusion of this trial
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Jan Salwa — Date: 12.17.09
Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

17349- Salwa, Jan

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

(This form has been approved by the New York State Department of Health)

Patient Name	Date of Birth	Social Security Number
Jan Salwa	[redacted]	[redacted]

Patient Address
100 Greenpoint Avenue, Apt. #2R., Brooklyn, NY, 11222-

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form in accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item #9(b). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(b), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM # (8).

7. Name and address of health provider or entity to release this information:
Ursula Kwiatek, MD 934 Manhattan Ave, Greenpoint, NY 11222

8. Name and address of person(s) or category of person to whom this information will be sent:
WORBY, GRONER, EDELMAN & NAPOLI BERN, LLP, 3500 Sunrise Highway, Suite T-207, Great River, NY 11739

9(a). Specific information to be released:

☑ Medical Record from (insert date) 1995 to (insert date) Present

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include (Indicate by Initialing)

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-Related Information

Authorization to Discuss Health Information

(b) Initials ☑ By initialing here JS I authorize Ursula Kwiatek, MD (Name of individual health care provider)

to discuss my health information with my attorney, or a government agency, listed here:

WORBY, GRONER, EDELMAN & NAPOLI BERN, LLP
(Attorney/Law Firm or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: Litigation	The conclusion of this trial
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

Jan Salwa Date: 12/7/09

Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably can be used to identify a person as having HIV, symptoms or infection and information regarding a person's contacts.

17139: Salwa, JAN